Brief to the Standing Committee On Social Policy

Legislative Assembly of Ontario

Submitted by
Service Employees International Union Local 1.on

Barbara Rankin and Jeff Rooney
(Union Representatives)

February 2, 2006
Thunder Bay, Ontario

I INTRODUCTION:

Good afternoon, my name is Jeff Rooney, and I am a Union Representative with the Service Employees International Union Local 1.on; and with me today is Barbara Rankin, also a Union Representative with SEIU Local1.on. Through our Thunder Bay Office, we both service a wide array of Health Care members in North-western Ontario, and will be sharing today's presentation to the Standing Committee.

SEIU Local 1.on represents 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services across Ontario.

The Local Health System Integration Act, 2005, Bill 36, in its present form will radically alter the kind of health care services Ontarians receive, how these services will be delivered, who will profit from the services delivered, and who will lose as a result of the integration, amalgamation and devolution of health care services.

Bill 36 transfers control over local community based health service providers to the Minister and Cabinet, and to their agents (LHINs), thereby centralizing, rather than localizing, control over health services in Ontario.

The Minister of Health and Long Term Care professes his commitment to the Canada Health Care Act, but demonstrates through this legislation, his attempt to further circumvent the principles of the Canada Health Act. We would have expected that the Preamble and Section I would have ensured the principles of the Canada Health Act.

As this bill now reads every health care service not covered by the Canada Health Act will be subject to privatization.

Bill 36 doesn't enhance health care. However, it does allow for cheaper delivery of these services at the expense of our members and our communities. LHINs will be forced to find the biggest bang for their buck, given their predetermined and limited finances.

The Ontario Liberal government promised it would deliver a balanced provincial budget before the next election in October 2007.

No LHIN will be allowed to have an operating deficit. Each LHIN must make due with the monies allocated to it by the provincial government. A LHIN can not borrow without the approval of the provincial government.

Therefore, this legislation is not about building a better health care system, but rather it is a way to control health care spending.

Even before the LHINs are operational, it is costing Ontario taxpayers millions of dollars in start up costs.

Millions more in public health care dollars have been and are being wasted on public private partnership hospitals.

Democratically accountable District Health Councils have been shut down.

Severance payments for 150 District Health Council administrators will cost $27 million. Many of these same people will in all likelihood be hired by LHINs.

Wind up costs for DHCs will be $ 5.9 million.

The hiring of 550+ new bureaucrats to operate the LHINs will cost $52 million.

Legal fees will add another $14 million.

Almost $200 million will be spent to set up a new LHIN bureaucracy. This will not add a single family doctor, medical specialist, or direct hands on care provider to Ontario's health care system.

Add to this the fact that the government has funded the Hospital Business Services Corporation in the Greater Toronto Area $42 million to eliminate full-time jobs at 16 GTA hospitals. The HBS will devolve "non-clinical services" to for profit providers. It is the exact pro-type the government wants the LHINs to follow.

The HBS is to provide various functions to member hospitals, including payroll, clerical, and materials management services. The HBS will have had the authority to move any non-clinical service from the hospitals to the HBS.

HBS will act as the broker agency to contract out all non-clinical clinical services to the private sector. On January 20th, SEIU Local 1.on heard from the HBS that all materials handling supply chain departments at the 16 GTA hospitals will work under the direction of HBS supervisors. The devolution process has already started.

When we reviewed the HBS model last year, we found no savings, or any return on investment that could be achieved.

If there is no community control over hospital services why should citizens bother to volunteer to raise funds or donate to specific hospital campaigns? If a LHIN has the power to move the service, the community raised funds for, why bother with the effort.

We have heard complaints about the rising compensation and salary costs of the health care budget from the previous government. Mr. Smitherman has also recently eluded to the same fact. Lets' face it; we're dealing with a services oriented sector which invariably involves people. It's not abnormal to spend 80% of the budget on Human Resources. Our members in the Hospital setting earn approximately $33,000 to $35,000 per year. Our members working as Personal Support Workers (PSW) in Home Care average approximately $26,000 which is exceedingly close to the poverty line. Can we refer to these salaries as being excessive – I think not! Compare this to the salaries of some the CEO's of these Hospitals who may earn in excess of $700,000 per year.

The previous government's attempts at containing health care costs resulted in the implementation of the Heath Tax whereby health care workers are now subsidizing their own wages up to $900 per year – figure that one out.

If you want to contain costs or trim fat, don't take blood from a stone. Our members are not the cause for rising health care costs.

The Honourable George Smitherman, in a speech to the Standing Committee on Bill 36 on January 30, 2006, stated;

"Reshaping. Fundamentally changing. Improving. That's what we set out to do to Ontario's health care system with this bill"

It wasn't difficult to conclude, after reading the Bill and with the interpretive assistance of several lawyers, that Bill 36 definitely was "reshaping" and "fundamentally" changing Ontario's health care system. The negative effects of which are only as limited as the

creator's imagination. What we don't understand, is how these changes are going to improve the current health care system.

One of the best strategies to combat your opposition is to beat them to the punch – in other words, prepare your audience for what to expect, while defending your position at the same time. That is exactly what Mr. Smitherman did when addressing the Standing Committee.

After forewarning the Standing Committee on what to expect throughout these presentations regarding Bill 36, Mr. Smitherman urges you to ask the following questions;

"Where does the Bill do that?"
"Where in the Bill does it say that?"

We suspect that this committee has the foresight and aptitude to deflect the rubbish which Mr. Smitherman has delivered. "Weasel words" won't confuse the educated. Remember, **Bill 36 has been carefully and cleverly crafted and we're not surprised that the Bill <u>doesn't specifically say</u>, and I quote;**

"The Local Health Integration Networks are going to extend the competitive bidding model to the entire public health care system."

Or we're not surprised that it doesn't say;

"Local Health Integration Networks will result in patients having to travel further for services"

or that it doesn't say ,

"Local Health Integration Networks will mean lost jobs and lower wages"

or ,

"Local Health Integration Networks are going to close hospitals"

The Bill, as written, provides the ability, or has the desired momentum for these outcomes to flourish – that's the problem. It's also what the Bill doesn't say, that scares us and those who are aware of this Bill.

In determining whether the Bill provides the opportunity or has the effect for these devastating changes to occur, we urge you to ask yourself the more appropriate question;

"Does the Bill prevent these situations from occurring?"

The answer to this question is simply **- NO**

In Smithermans speech, on more than a half dozen occasions, he referred to decisions being made by people closer to the action. Although we are hopeful that the composition of the LHINs will be comprised of local individuals, we are concerned that these same individuals are being appointed by Cabinet as opposed to being elected.

Section 1 of the Bill describes LHINs as being charged with the "management of the health system at the local level". The LHIN's will be governed by a board of directors, which will be appointed by Cabinet (S7 and 8) but with no real independence from Government. In fact, each member continues on the Board at the "pleasure" of Cabinet and, as such, may be removed at any time without cause. Reappointment is also entirely dependent upon Cabinet. .

The only members of the LHIN non-profit corporations are government-selected directors (s7(2)). Section 4(1) specifically defines a LHIN as an "agent of the Crown". In other words, it acts on behalf of the government. How better to serve your needs than by hand picking your servants.

LHINs has taken the appearance of a pawn; created, hand picked and controlled by the player. In this case, it's the government.

Section 17 (1) states that LHINs are funded by the Ministry "on the terms and conditions that the Minister considers appropriate". Each LHIN must successfully negotiate an accountability agreement with the Ministry, however, if unsuccessful, Section 18 states that "the Minister may set the terms of the agreement". While each LHIN is to develop "an integrated health service plan" for the locality over which it presides, this plan must be made within the time and in the form specified by the Minister and be consistent with a provincial strategic plan that is developed by the Minister (sec. 15).

Smitherman has stated that, "decisions would be based on priorities set in communities and taken at open public meetings". Our region of the province has been labelled as the "North West Health Integration Network". The boundaries of this LHIN are from the Manitoba border (approximately 600 kilometres west of Thunder Bay) to White River (approximately 400 kilometres east of Thunder Bay). This LHINs boundaries span 1,000 kilometres if travelled in a relatively straight line. However, lets not forget the communities North of Thunder Bay and the distances involved in reaching them (IE: Nakina – nearly 400 Kilometres North of Thunder Bay).

Section 9 suggests that LHIN meetings are to be public. Now lets be realistic. Making meetings public is one thing, making them accessible is another. Being a citizen and living in North-western Ontario, we often struggle with the ignorance associated with the vast size of our region. Lets be clear, we will demand, if this Bill is passed, that these LHIN meetings would be conducted in each community that may be affected by a decision.

Expecting someone to drive upwards of 1,000 kilometres to attend a "Local meeting" hardly seems appropriate. I'm sure you realize how many communities are situated in our region and how many days or weeks it may take to conduct these meetings; **but lets not forget, and I once again refer to Mr. Smitherman's comments, "priorities set in communities" and "more responsive to the needs of the community"** - how can the government be more responsive or set priorities for a community if they don't allow opportunity for the communities to provide their input.

The LHIN legislation is nothing more than the Ontario governments attempt to control health care costs by privatizing non-clinical services and integrating other services, meaning patients will have to travel hundreds of Kilometres.

Forestry is the mainstay for many of our communities. Over the past few years, we have seen mill closures and drastic layoffs with more anticipated. The effects to our local communities have been devastating. Many would believe that little has been done by the way of government intervention, and what has been done has been too little, too late. Now, it appears as though we will be facing another round of job loss and demolition to our communities.

The smaller communities within our geographical region will likely be affected the most; with services being moved to larger communities. If services are removed, undoubtedly it will result in job loss. It doesn't become an issue of moving from one employer to another or from one location to another. It's a matter of removing decent paying jobs out of communities which have already been teetering on the brink of existence. Without decent paying jobs, existence becomes futile. Individuals will be forced to abandon their communities and relocate to metropolitan centers such as Toronto or to another Province – it's already occurring daily. We simply can't afford another blow to these communities.

Once the jobs are gone, and the residents follow suit, what do you think happens to the community – it naturally moves closer extinction. We understand that it's hard for some

Ontarians living outside of Northern Ontario to believe that houses are typically sold for $20, 000 - $40,000 in some of these smaller communities. Who wants to move to a community that has nothing to offer? It's not even as though you could live in one community and commute to another because odds are, the community beside you has nothing to offer either - not to mention the significant distances between communities. Having said this, houses often do get sold. Americans and southern Ontarians buy and use these houses as summer getaways or vacationing destinations. After all, the hunting and fishing is superb. Neither did Smithermans recent speech, or Bill 36, protect loss of jobs in communities.

Once these services are moved to the larger communities, they run the risk of being privatized. Remember, the LHINs will be forced to contain costs, given their predetermined amount of money to provide services. So now, our decent paying jobs ($33,000 - $35,000) would be shifted to the for-profit private sector. The government may argue that the result is simply a shift in Employers; but let's not forget, the private sector will not be bound by the collective agreement our members once enjoyed. Now they may only earn $7.75per hour (minimum wage) which represents approximately ($16,000) per year. Not acceptable!

The government is moving this legislation forward, without having a strategic plan in place for the delivery of health care in Ontario.

This legislation is flawed because its premises are based on cost containment of health care services and not on ensuring Ontarians have equal access to quality public health care services.

In effect Bill 36 is nothing more than Ontario Liberal government's cost containment strategy. Privatization schemes that will reduce human resources costs is the route the government has chosen.

The real name of this legislation should be Ontario's Balanced Budget Act for the 2007 Election.

Barb Rankin

Hello, my name is Barb Rankin. I've been working for the members of Service Employees Union for over 20 years now, and one of the first meetings I attended with representatives from the government was to discuss healthcare restructuring. At that time there were stakeholder meetings taking place around the province, and the goal was to, we believe save money, much as the goal is to save money with the LHINs restructuring, but of course, both initiatives always on the basis of providing better care.

I'm raising this story with you because it will give you an idea of why we are concerned about the legislation and what overall sweeping powers this legislation incorporates.

When I went to the meetings, the theory was the patients in hospitals should be moved out into the community quicker and they should not be in chronic hospitals or nursing homes if care could be provided in their own home. They would have a better quality of life and the government could provide those health care services more economically in their homes.

Seemed simple.

The Union people at the meeting asked questions and raised concerns such as: how can you move them into the community when there isn't any support set up for them in the community, and we had concerns that that will mean less staff working in the hospitals, so our members who had reasonably paid jobs who could support their families, and who

could help contribute towards our community, would be out of a job. What's the real driving reason behind it? Are the people really going to get better care in the community?

We know we have homemakers that we have since organized in the community and those homemakers give fabulous care, but they are only allowed to give visits of a half hour in duration, an hour in duration, based on what the Community Care Access Centre prescribes. We know that those homemakers are paid substantially less than the employees who were working in the hospital, and in fact we go so far as to say those homemakers are subsidizing the healthcare system. They are not adequately reimbursed for their vehicle maintenance or for the gas that goes into their vehicles. They are, at times when they go out to see a client, actually losing money. So that's how that system worked. The savings, if any, were on the backs of the workers.

We're raising these issues because we said back then to the government. You know what? There are problems with how you're thinking this through. We don't think it's going to work how you're saying it's going to work, and this is what we believe is going to happen.

We think that it's going to be deferring much of the public money to private enterprise, and what does private enterprise need to do? They need to make a profit. So, in fact, the government is providing the private enterprise with a profit and that money is not going to the patients, residents, or clients who need it.

We believe this is exactly what will happen with the LHINs. And, mark our words. That's what we see happening. The cataract clinic in Toronto is a prime example.

When we look at the legislation, and we see sections like Article 2, which defines integration:

to partner with another person or entity in providing services and operating

to transfer, merger or amalgamate services, operations, persons or identity

to start or cease providing services. And, when you look at that in the context of the Local Health Integration Networks having that power to do those integration procedures, we have a whole lot of concern.

It's all very complicated of course, and it makes it hard for us regular people to understand. But, when I take a step back and look at this, this is what it means to me. It means the Minister of Health – Mr. George Smitherman transferring the majority of the health care budget – made up of our tax dollars - to Gwen Dubuois Wing, at the Northwest Local Health Integration Network, and then that's it for the Minister of Health. He tells Gwen this is your budget, and that's that. Make sure it is adhered to. Then the LHIN gets Hospital CEO's to sign off or their wages will be decreased by 10% if they don't balance the budget – it's blackmail and it's ridiculous. The CEO's don't' have total control.

The Health Integration Network makes their decision, much like how the CCAC makes their decisions, but you can't really find out how they're making their decisions because they were excluded from the Privacy Information Act.

Anyway, the Health Integration Networks make those decisions and say for example they make the decision that, you know what, Thunder Bay, you're not going to do hip replacement surgery any more. That's all going to be done in Sudbury. And the public says no, we don't want hip replacement down in Sudbury. We need that here. So then we go to the Local Health Integration Network and they say no, we've made that decision and we've done that in consultation and it's a local decision, so it's a good one. And we say, well we don't accept that. So then we go to the Minister of Health and the Minister of Health says, no, the Local Health Integration Network has made that decision. They're your local body and that's it. So, where do we go from there?

You say it's a local decision-making group, but really the positions are appointed and we don't have any say over who is allocating our tax dollars.

I think it's just the Ministry of Health's way of deflecting responsibility.

II They are undemocratic.

LHIN Boards are unelected. Each LHIN director appointed by Order – In –Council means they are only accountable to the Minister of Health and Long Term Care.

Section 7 and 8 of Bill 36 must be amended to provide for the election of LHIN Boards of Directors.

Section 16 states the LHIN is to "engage community." We ask at what level? What community interests are to be taken into account and to what degree? Reconsiderations of LHIN decisions as outlined in Section 26 and 27 do not allow affected parties much time to

appeal (30 days). Will unions holding bargaining right have the right to the reconsideration process? The very short time frame for any party to make a submission for reconsideration and to study the impact a LHIN Board decision will have on local health services suggests the government wants to limit the appeal process.

Why does the government draw the line at the health care providers as defined in the Act. Why are Independent Health Facilities, physicians, laboratories and ambulances not included?

Why are independent health facilities outside the scope of this legislation? Is it because ancillary services at these clinics can be charged to patients and services these clinics provide can more easily de de-listed?

The establishment of stand alone specialty clinics belies the government's intention for greater local control over health care services. These independent health facilities could be operated as private clinics, but funded by public health care dollars.

We note also that a LHIN is to establish an advisory committee of health professionals, but physicians are excluded from this legislation. How can doctors act in an advisory role without being part of the entire health system?

Section 14 and 15 of the Act must be amended to allow for community control and input in the planning process.

If the bureaucrats and elected members can't tell what is going on with Bill 36 this legislation should not pass until citizens know how it will affect their health care system.

This legislation gives near dictatorial powers to the Ontario Minister of Health and Long Term Care. The Minister of Health will have greater control over the kind, type and amount of health care that is provided in each LHIN in Ontario.

Section 26 of the Act allows a LHIN to:

1. Provide all or part of a service or to cease to provide all or part of a service.
2. To provide a service to a certain level, quantity or extent.
3. To transfer all or part of a service from one location to another.
4. To transfer all or part of a service or receive all or part of service from another person or entity.
5. To carry out another type of integration of services that is prescribed.
6. To do anything or refrain from doing anything necessary for the health service providers to achieve anything under any of the above listed including transfer of property or to receive property from another person or entity.

Section 28 of the Bill allows the Minster of Health to order a health service provider that carries out its operations on a not for profit basis to cease operating, to dissolve or to wind up its operations; amalgamate with one or more health service providers; transfer all or substantially all of its operations to one or more persons or entities; and to take any other action necessary to transfer property.

LHIN powers to order integrations are limited only by the fact they cannot order a health service provider to cease operating, dissolve or wind up.

But what the LHINs lack in power, the Minister of Health can do.

Section 33 will allow the government to order health service providers to cease operating and transfer their property [section 28(1)]. This leaves the door wide open to greater privatization of heath care services.

For example a LHIN could require the transfer of health care services, such as chronic care, from a public hospital to a private for profit nursing home.

III. HUMAN RESOURCES

Last summer SEIU Local 1.on met with several Liberal MPPs to relay our concerns about the lack of nursing home standards, the quality and continuity of care in the home care sector, and the private financing and construction of Ontario hospitals and our concerns about the Local Health Integration Networks.

In every case the Ontario government broke election promises to the people of Ontario and specific commitments it made to SEIU prior to the last election regarding health care.

Many Liberal MPPs told SEIU members that it was not the intention of this government to achieve health care cost savings on the backs of health care workers.

Were we again misled? Clearly this legislation will affect every health care worker's livelihood.

Hospital service workers continue to see their jobs in dietary and housekeeping contracted out to for profit operators. Direct patient care providers are leaving their jobs because they can no longer cope with the stress. Non-clinical staff is asked to do more and more with less. Hospital cleanliness has been neglected to the extent that infectious diseases are increasing at alarming rates.

Home care workers continue to be subjected to "competitive bidding" that simply removes their jobs from them every three to five years, because this government believes competition is good for home care.

Bill 36 will extend the competitive bidding model to all other health care services.

Everything is for sale including workers' livelihoods.

Shortly after having become Premier, Dalton McGuinty said he believed in public health care. We have not heard him say that recently, particularly now that he is giving a large chunk of our $900 per year Health Tax to the private consortiums building for profit hospitals.

And is this not what this legislation is all about? Transferring public health care assets to private for profit enterprises?

SEIU Local 1.on represents mainly service, clerical and home care workers in Ontario's health care sector.

That's why we are very concerned about Bill 36's terminology "non-clinical services."

Section 33(1) will allow the government to cease performing any prescribed non clinical service and to integrate the service by transferring it to the prescribed person or entity. This section of the Bill gives the government the right to privatize more health services particularly "non-clinical services."

Each LHIN must identify opportunities for integration (Sec. 24).

The broad definition of services and the right of the LHIN to move any non-clinical service means only one thing, the devolution of these services to for profit providers.

A person or entity is defined under the health service provider definition [Section 2 (2)]. This includes "any other person or entity or class of persons or entities that is prescribed [Section (2 (2) (ii)].

Any time a transfer of a service, a person, or entity under an integration order, the transfer of all or substantially all of the operations of a health service provider and the amalgamation of two or more persons or entities under integration decision the, *Public Sector Labour Relations Transition Act*, 1997 will apply.

However, if the successor employer is not a health service provider and the primary function of that entity is not the provision of services within or to the health care sector, then it will not apply. "Non-clinical" service transfers will be subject to the provisions of "successor employer" and "sale of business" provisions under the *Ontario Labour Relations Act* [Sec. 32(3)].

PSLRTA will not apply where the Ontario Labour Relations Board issues an order declaring that it does not apply. In other words, the government wants to remove the protection of current collective agreements from health care workers.

Displaced non-clinical service workers will have no right to transfer their union contracts to the for profit private provider of non-clinical services.

Many health care workers are immigrants and women.

Does the Ontario government really want to create a class of health care workers toiling for poverty level wages, with no benefits and no pensions?

The proposed legislation offers an exact definition of a "health care provider," but "non-clinical services" have no exact definition. This can mean only one thing. The government wants the ability to privatize more health care services over time.

The term "services" has a broad definition and includes direct services and programs, support services and functions that support the operations of the person or entity that provides a direct or support service or program, (Section 23).

Competition in the home care sector has eroded the continuity and quality of care. Competition in the rest of the health care sector will do the same.

With the transfer, amalgamation and integration of health services, SEIU Local 1.on anticipates a plethora of PSLRTA (Bill 136 votes). Bill 136 will create labour chaos as the integration and amalgamation of services between health care providers begins.

A transfer of three registered technologists from hospital A to hospital B could trigger a Bill 136 vote, if different bargaining agents represent workers at the different hospitals.

If non-clinical services devolve to private corporations, their labour relations will be subject to the Ontario Labour Relations Act. Workers providing these services to hospitals and other health care institutions would, we assume, have the right to strike.

If the government wants to avoid labour chaos, it must not use the Ontario Labour Relations Act to govern "non-clinical services."

It is essential that a human resources plan be developed.

Health care sector workers' rights must be protected.

PLSTRA should apply to all health care restructuring, regardless of whether a successor employer operates mainly in or out of the health care sector.

Nothing in this legislation or any other legislation must override collective agreements or trade union representation rights.

Health care workers must be assured their jobs are protected, their wages and benefits are protected, and their pensions are protected.

No integration decision made by the government or a LHIN must alter the terms and conditions of employment of an employee including collective agreements without their union's consent.

The application of PLSTRA should not be subject to the discretion of the Ontario Labour Relations Board.

Any restructuring of health services including integration, amalgamation, or devolution of services must not be finalized until all affected employees and their unions are notified and a human resource adjustment plan has been agreed to.

It is the only way Ontario citizens will be assured of quality and continuity of care.

IV. CCACs

SEIU Local 1.on is Ontario's largest home care union. The current 42 Community Care Access Centres will be restructured to fit the 14 LHINs. Part VII of Bill 36 will return the CCACs to a corporate structure similar to a structure that existed prior to 2001. CCACs will have the power to select their own directors and hire their own executive directors.

The integration of 42 CCACs into 14 LHIN will have serious consequences for both home care clients and service providers.

CCACs now contract for home care services though a Request for Proposals process. Both for profit and non profit home care agencies deliver services, Private home care operators have had their market share enlarged.

The RFP process has done nothing to ensure home care clients receive quality service and continuity of care.

The RFP process has subjected home care workers to second class worker status in the province of Ontario. Every time a contract, though the RFP process is tendered, home care workers lose their jobs. They are not entitled to "successor rights" under the Ontario Labour Relations Act, even though the replacement agency has no employees of its own when it bids on the contract. It simply attempts to hire the previous agency's staff.

All that is wrong with the RFP process will be exacerbated when 42 CCACs are integrated into the 14 LHINs and provider agencies must be realigned to fit this new reality.

Continuity of care in home care services must mean there must be an immediate end to the "competitive bidding model" for home care services.

Contrary to Elinor Caplan's observation "that competition is good in the home care sector," all the evidence leads to a contrary conclusion.

The fundamental element of a home care delivery process must be the continuity and quality of care patients receive.

Having home care agencies lose or gain contracts within the 3 to 5 year period of service agreements only leads to disruption in patient care. Home care workers are exiting the home care sector, because they can not put up with the job insecurity and the poverty level wages.

The best way to ensure quality and continuity of home care services is to have the CCAC be the employer. CCACs already set the care plans and decide on the levels of care. Managing the care givers is a logical continuation of the care plan.

A strategic plan for health care in Ontario must include a human resource plan that gives equal employment rights to home care workers that all other Ontario workers enjoy.

At the very least a human resources plan based on the current home care delivery model must:

- Guarantee a new agency to continue to employ the employees of the home care agency they plan to replace.
- Guarantee to recognize and provide the same working conditions, seniority, wages and benefits the employees had with the displaced agency. Wages and benefits must reflect the prevailing union or highest wage rate within the CCAC's geographical jurisdiction.
- Recognize the union representing the employees of the home agency that is being replaced.
- The successful home care agency in the RFP process must be bound to any existing collective agreements with the union that represented the employees with the previous agency.

Only a stable, professional and fairly compensated workforce will ensure Ontarians they will have quality as well as continuity of health care services.

Home care service agencies are not defined as a health care provider in the Act, despite the fact home care services clearly fit the definition of an employer whose primary function is the provision of services within or to the health services sector as defined under the health services integration.

V. CONCLUSION

In conclusion we'd like to make the following points:

We know there are problems in the healthcare system. We know we need to have reduced wait times for life-saving surgery and treatment. We, in this area, don't feel it makes any sense to have to travel to southern Ontario for certain procedures and have to pay out of pocket for that.

You have to go back and have true consultation. Having meetings like this, although it's important, it doesn't help you out. I think you need to actually have the nitty gritty discussions with the people who are working in the system right now, and the way this legislation is set up to exclude the doctors, I can't imagine how you're going to make changes without including them.

So, we're saying, yes there needs to be changes. Is this the way to go about doing it? No, we don't' think so. We think it's just an additional layer of bureaucracy in a system that isn't required.

Bill 36 is a revolution in health care. There will be a lot of carnage left on the battle field if this legislation passes in its present form.

Everyone wants reduced wait times for life saving surgeries and treatments.

Can the government really manage wait times without physician involvement? Wait times speak to the fact that there are not enough family physicians.

A wellness program would have been a better model to reduce wait times than the legislation we have in front of us today.

With 14 LHINs, each setting priorities for their region, what guarantee does a patient have to equal access and equal wait time queues in Kenora, Kapuskasing or Kincardine, compared to a patient in Toronto?

There is nothing seamless about the integrated health system the Minister of Health envisions.

Bill 36 says nothing about the quality of care or services the LHINs will deliver. This Bill is all about the bottom line, how to balance the provincial budget prior to the 2007 election. Ontario's health care consumers and health care workers be dammed.

The composition of the LHIN boards must specify that all members of the LHINs are residents of the LHIN.

A provincial strategic plan needs to be in place before the LHINs can even start to develop their plans (Sec. 14 & 15).

The strategic plan must also include a human resources plan.

SEIU Local 1.on asks the members of this committee to delay third reading until this government has held broad consultations with all stakeholders. The MOHLTC must develop a strategic plan in consultation with the public.